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IIMAC Update on DOH Opioid Prescribing Rules Task Force

September 26, 2017

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WA Leads on Reversing the Epidemic

- 2005 – First report of prescription opioid-related deaths (Franklin et al, Am J Ind Med 2005; 48:91-99)
- 2007 – AMDG Guideline was first U.S. guideline with a dosing threshold of 120 mg/day MED (updated in 2010 & 2015)
- 2010 – First report of clear association between high doses and overdoses (Dunn, Von Korff et al, Ann Int Med 2010; 152: 85-92)
- 2010 – WA legislature repeals old, permissive rules and establishes new standards for all prescribers (ESHB 2876 and DOH rules)
- 2011 – UW TelePain/ECHO provides free educational consultations to community clinicians by multidisciplinary panel
- 2012 – Provider access to Prescription Monitoring Program data
- 2013 – L&I implemented opioid guidelines and rules in workers' compensation (www.Opioids.Lni.wa.gov)

Franklin et al. Am J Public Health 2015 Mar;105(3):463-9

State Opioid Response Plan

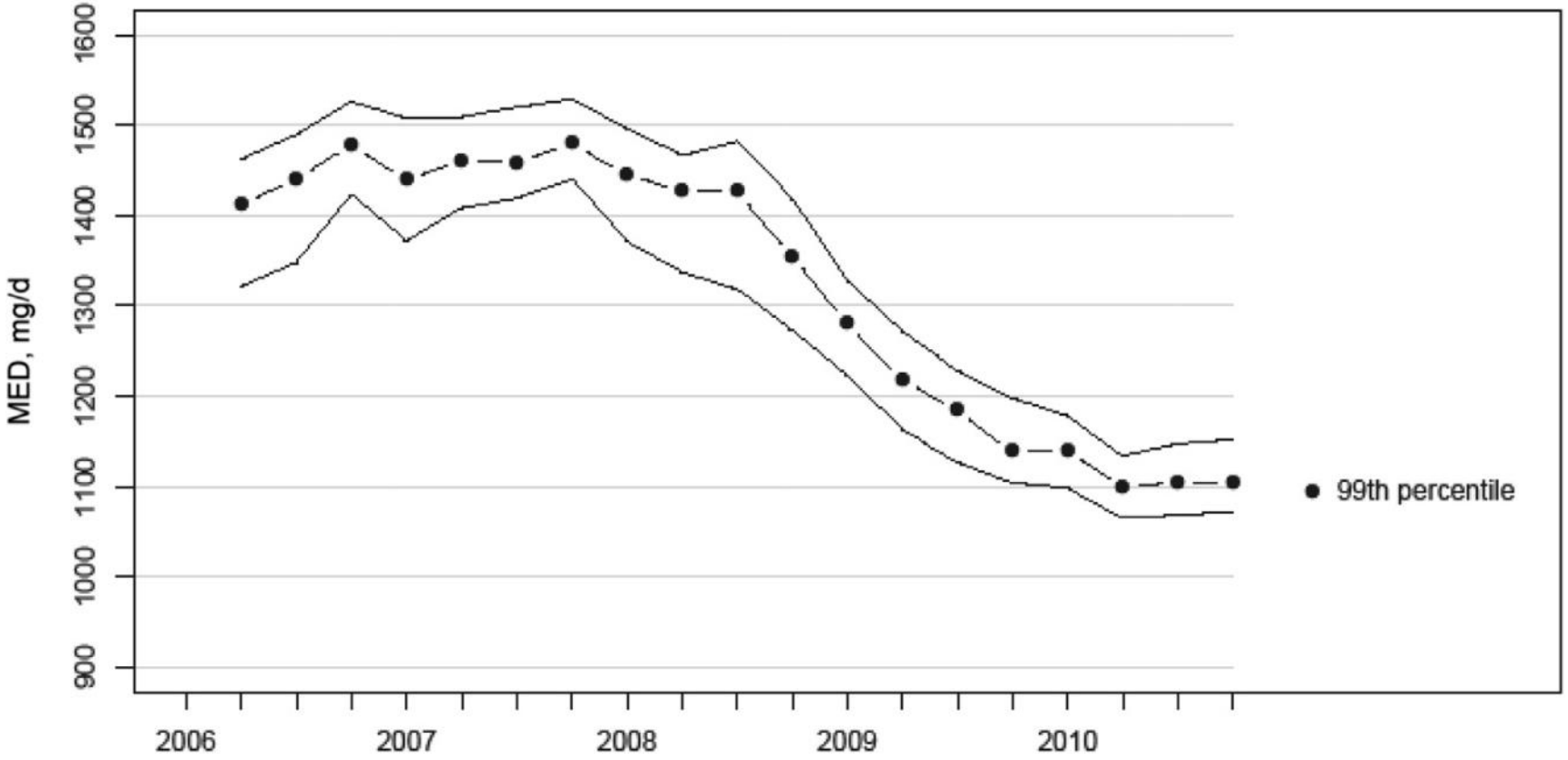
Priority Goals

Goal 1: Prevent Opioid Misuse & Abuse	Goal 2: Treat Opioid Use Disorder	Goal 3: Prevent Deaths from Overdose	Goal 4: Use Data to Monitor and Evaluate
↓	↓	↓	↓
Improve Prescribing Practices	Expand Access to Treatment	Distribute naloxone to heroin users	Optimize and expand data sources

Priority Actions

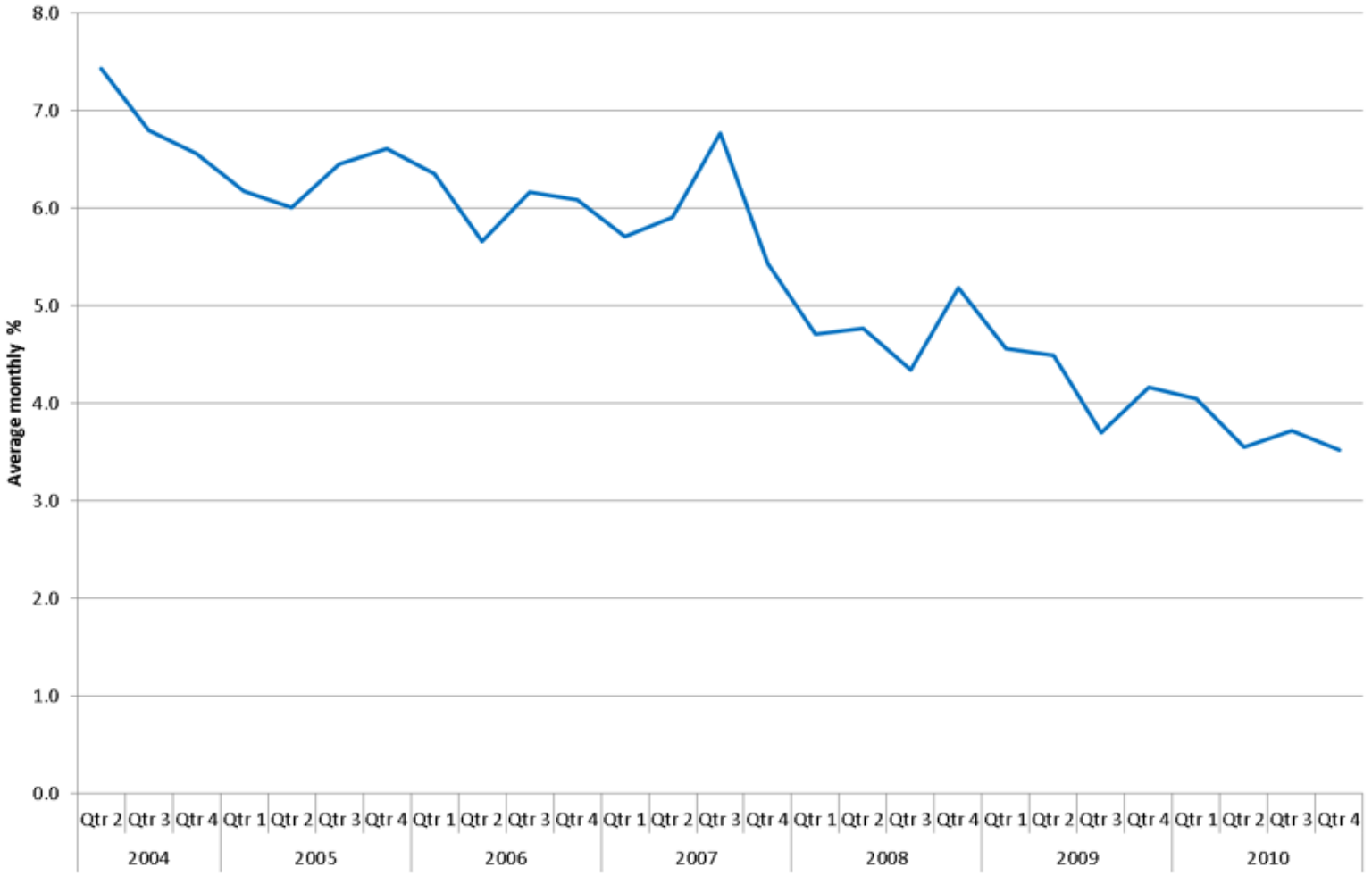
http://stopoverdose.org/section/wa-state-interagency-opioid-working-plan/

Reduced high dose prescribing in WA Medicaid post-dosing guideline



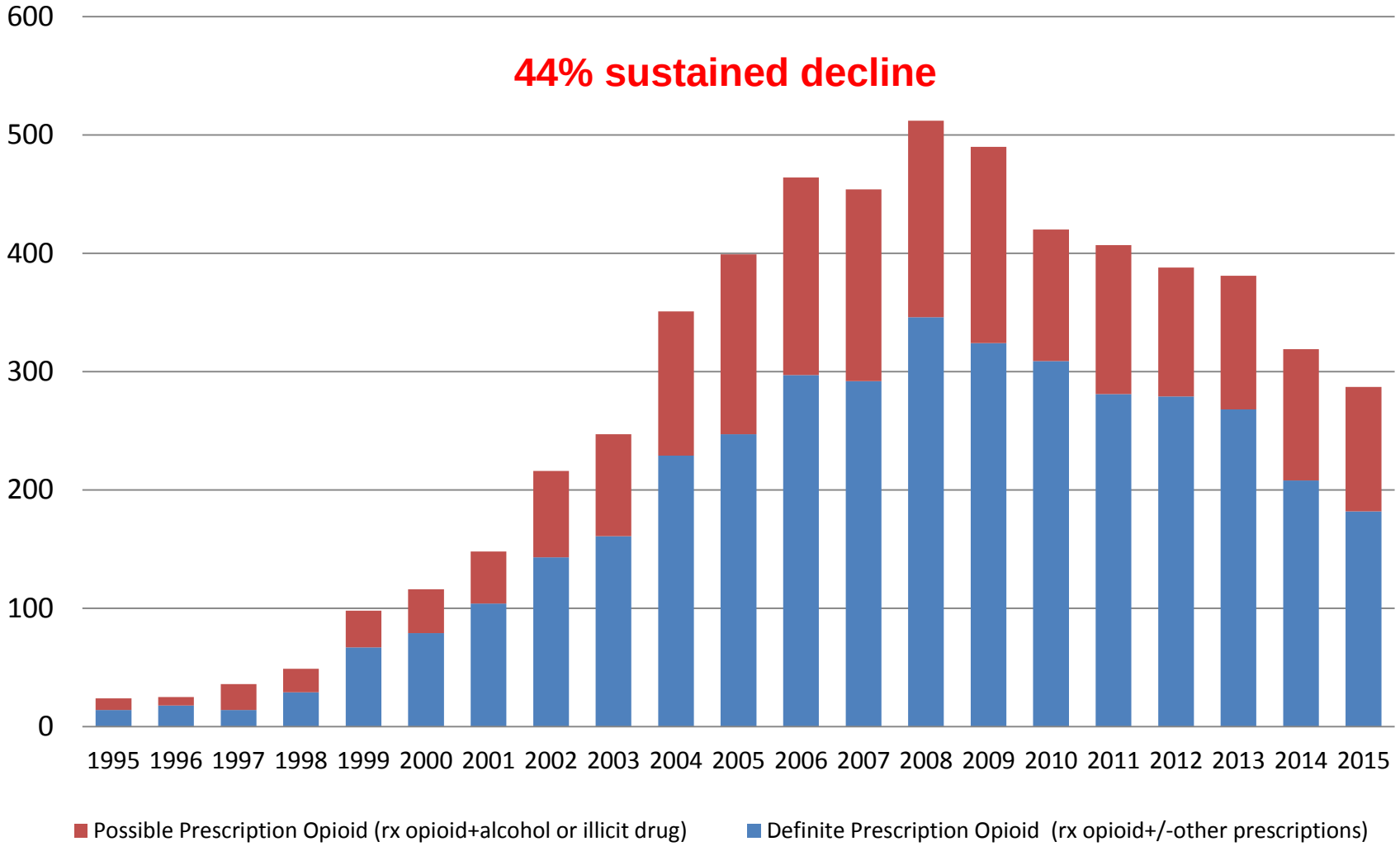
Sullivan et al. J Pain 2016;17:561-8

Reduced rate of incident users who became chronic user in WA Workers' Compensation

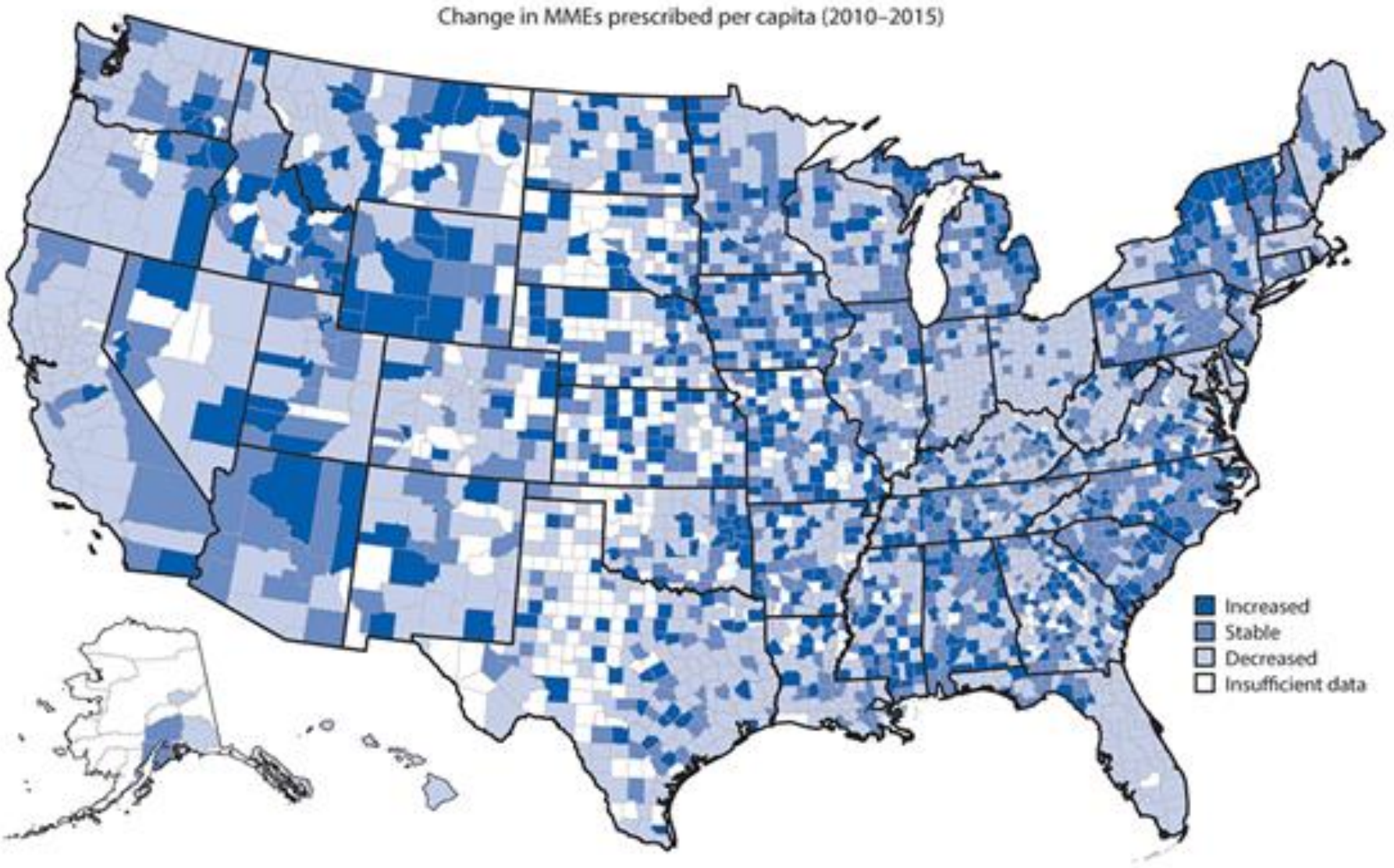


Garg et al. J Pain 2013 Dec;14(12):1620-8

Reduced unintentional *prescription* opioid deaths in Washington



Source: Washington State Department of Health



Guy GP Jr., Zhang K, Bohm MK, et al. Vital Signs: Changes in Opioid Prescribing in the United States, 2006–2015. MMWR Morb Mortal Wkly Rep 2017;66:697–704. DOI: http://dx.doi.org/10.15585/mmwr.mm6626a4

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Since ESHB 2876 …

Summary of
2015 Interagency Guideline on Prescribing Opioids for Pain

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See full guideline at
www.AgencyMedDirectors.wa.gov

All pain phases

- Use non-opioid therapies, such as behavioral intervention, physical activity and non-opioid analgesics.
- Avoid opioids if the patient has significant respiratory depression, current substance use disorder, history of prior opioid overdose or a pattern of aberrant behaviors.
- Assess and document function and pain using a validated tool at each visit where opioids are prescribed.
- Don't prescribe opioids with benzodiazepines, carisoprodol, or sedative-hypnotics.

Acute phase (0–6 weeks)

- Check the state's Prescription Monitoring Program (PMP) before prescribing.
- Don't prescribe opioids for non-specific back pain, headaches, or fibromyalgia.
- Prescribe the lowest necessary dose for the shortest duration.
- Opioid use beyond the acute phase is rarely indicated.

Perioperative pain

- Evaluate thoroughly preoperatively: check the PMP and assess risk for over-sedation and difficult-to-control pain.
- Discharge with acetaminophen, NSAIDs, or very limited supply (2–3 days) of short-acting opioids for some minor surgeries.
- For patients on chronic opioids, taper to preoperative doses or lower within 6 weeks following major surgery.

Subacute phase (6–12 weeks)

- Don't continue opioids without clinically meaningful improvement in function (CMIF) and pain.
- Screen for comorbid mental health conditions and risk for opioid misuse using validated tools.
- Recheck the PMP and administer a baseline urine drug test (UDT) if you plan to prescribe opioids beyond 6 weeks.

Chronic phase (>12 weeks)

- Continue to prescribe opioids only if there is sustained CMIF and no serious adverse events, risk factors, or contraindications.
- Repeat PMP check and UDT at frequency determined by the patient's risk category.
- Prescribe in 7-day multiples to avoid ending supply on a weekend.
- Don't exceed 120 mg/day MED without a pain management consultation.

over

When to discontinue

- At the patient's request
- No CMIF
- Risks outweigh benefits
- Severe adverse outcome or overdose event
- Substance use disorder identified (except tobacco)
- Aberrant behaviors exhibited
- To maintain compliance with DOH rules or consistency with AMDG guideline

Considerations prior to taper

- Help the patient understand that chronic pain is complex and opioids cannot eliminate pain.
- Consider an outpatient taper if the patient isn't on high-dose opioids or doesn't have comorbid substance use disorder or other active mental health disorder.
- Seek consultation if the patient failed previous taper or is at greater risk for failure due to high-dose opioids, concurrent benzodiazepine use, comorbid substance use disorder or other active mental health disorder.

How to discontinue

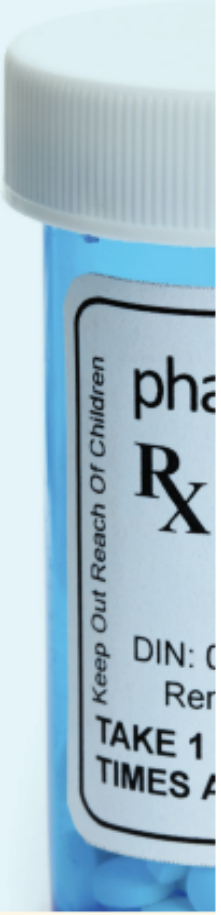
- Taper opioids first if patients are also on benzodiazepines.
- Unless safety considerations require a more rapid taper, start with 10% per week and adjust based on the patient's response.
- Don't reverse the taper; it can be slowed or paused while managing withdrawal symptoms.
- Watch for unmasked mental health disorders, especially in patients on prolonged or high-dose opioids.

Recognizing and treating opioid use disorder

- Assess for opioid use disorder and/or refer for a consultation if the patient exhibits aberrant behaviors.
- Help patients get medication-assisted treatment along with behavioral therapies.
- Prescribe naloxone (especially if you suspect heroin use) and educate patient's contacts on how to use it.

Special populations

- Counsel women before and during pregnancy about maternal, fetal, and neonatal risks.
- For children and adolescents, avoid prescribing opioids for most chronic pain problems.
- In older adults, initiate opioids at 25–50% lower dose than for younger adults.
- For cancer survivors, rule out recurrence or secondary malignancy for any new or worsening pain.



Check out the resources at
www.AgencyMedDirectors.wa.gov

- Free online CME
- Opioid Dose Calculator
- Videos from Primary Pain Care Conference

CDC Guideline for Prescribing Opioids for Chronic Pain — United States, 2016

CDC RECOMMENDATIONS

DETERMINING WHEN TO INITIATE OR CONTINUE OPIOIDS FOR CHRONIC PAIN

1 OPIOIDS ARE NOT FIRST-LINE THERAPY
Nonpharmacologic therapy and **nonopioid pharmacologic therapy** are preferred for chronic pain. Clinicians should consider opioid therapy only if expected benefits for both pain and function are anticipated to outweigh risks to the patient. If opioids are used, they should be combined with nonpharmacologic therapy and nonopioid pharmacologic therapy, as appropriate.

Nonpharmacologic therapies and nonopioid medications include:
- Nonopioid medications such as acetaminophen, ibuprofen, or certain medications that are also used for depression or seizures
- Physical treatments (eg, exercise therapy, weight loss)
- Behavioral treatment (eg, CBT)
- Interventional treatments (eg, injections)

2 ESTABLISH GOALS FOR PAIN AND FUNCTION
Before starting opioid therapy for chronic pain, clinicians should establish treatment goals with all patients, including realistic goals for pain and function, and should consider how opioid therapy will be discontinued if benefits do not outweigh risks. Clinicians should continue opioid therapy only if there is clinically meaningful improvement in pain and function that outweighs risks to patient safety.

3 DISCUSS RISKS AND BENEFITS
Before starting and periodically during opioid therapy, clinicians should discuss with patients known risks and realistic benefits of opioid therapy and patient and clinician responsibilities for managing therapy.

OPIOID SELECTION, DOSAGE, DURATION, FOLLOW-UP, AND DISCONTINUATION

4 USE IMMEDIATE-RELEASE OPIOIDS WHEN STARTING
When starting opioid therapy for chronic pain, clinicians should prescribe **immediate-release opioids** instead of extended-release/long-acting (ER/LA) opioids.

Immediate-release opioids: faster acting medication with a shorter duration of pain-relieving action

Extended release opioids: slower acting medication with a longer duration of pain-relieving action

5 USE THE LOWEST EFFECTIVE DOSE
When opioids are started, clinicians should prescribe the lowest effective dosage. Clinicians should use caution when prescribing opioids at any dosage, should carefully reassess evidence of individual benefits and risks when considering increasing dosage to ≥50 **morphine milligram equivalents (MME)/day**, and should avoid increasing dosage to ≥90 MME/day or carefully justify a decision to titrate dosage to ≥90 MME/day.

Morphine milligram equivalents (MME)/day: the amount of morphine an opioid dose is equal to when prescribed, often used as a gauge of the abuse and overdose potential of the amount of opioid that is being given at a particular time

6 PRESCRIBE SHORT DURATIONS FOR ACUTE PAIN
Long-term opioid use often begins with treatment of acute pain. When opioids are used for acute pain, clinicians should prescribe the lowest effective dose of immediate-release opioids and should prescribe no greater quantity than needed for the expected duration of pain severe enough to require opioids. Three days or less will often be sufficient; more than seven days will rarely be needed.

LEARN MORE | www.cdc.gov/drugoverdose/prescribing/guideline.html

7 EVALUATE BENEFITS AND HARMS FREQUENTLY
Clinicians should evaluate benefits and harms with patients within 1 to 4 weeks of starting opioid therapy for chronic pain or of dose escalation. Clinicians should evaluate benefits and harms of continued therapy with patients every 3 months or more frequently. If benefits do not outweigh harms of continued opioid therapy, clinicians should optimize other therapies and work with patients to taper opioids to lower dosages or to taper and discontinue opioids.

ASSESSING RISK AND ADDRESSING HARMS

8 USE STRATEGIES TO MITIGATE RISK
Before starting and periodically during continuation of opioid therapy, clinicians should evaluate risk factors for opioid-related harms. Clinicians should incorporate into the management plan strategies to mitigate risk, including considering offering **naloxone** when factors that increase risk for opioid overdose, such as history of overdose, history of substance use disorder, higher opioid dosages (≥50 MME/day), or concurrent **benzodiazepine** use, are present.

Naloxone: a drug that can reverse the effects of opioid overdose

Benzodiazepine: sometimes called "benzo," is a sedative often used to treat anxiety, insomnia, and other conditions

9 REVIEW PDMP DATA
Clinicians should review the patient's history of controlled substance prescriptions using state **prescription drug monitoring program (PDMP)** data to determine whether the patient is receiving opioid dosages or dangerous combinations that put him or her at high risk for overdose. Clinicians should review PDMP data when starting opioid therapy for chronic pain and periodically during opioid therapy for chronic pain, ranging from every prescription to every 3 months.

PDMP: a prescription drug monitoring program is a statewide electronic database that tracks all controlled substance prescriptions

10 USE URINE DRUG TESTING
When prescribing opioids for chronic pain, clinicians should use urine drug testing before starting opioid therapy and consider urine drug testing at least annually to assess for prescribed medications as well as other controlled prescription drugs and illicit drugs.

Americans, aged 12 or older, either abused or were dependent on prescription opioids in 2014

11 AVOID CONCURRENT OPIOID AND BENZODIAZEPINE PRESCRIBING
Clinicians should avoid prescribing opioid pain medication and benzodiazepines concurrently whenever possible.

12 OFFER TREATMENT FOR OPIOID USE DISORDER
Clinicians should offer or arrange evidence-based treatment (usually **medication-assisted treatment** with buprenorphine or methadone in combination with behavioral therapies) for patients with opioid use disorder.

Medication-assisted treatment: treatment for opioid use disorder including medications such as buprenorphine or methadone

LEARN MORE | www.cdc.gov/drugoverdose/prescribing/guideline.html

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Comparison between AMDG and CDC – See Handout

- Differences in opioid prescribing focus
  - CDC: chronic non-cancer pain, including opioid initiation for acute pain
  - AMDG: all phases (acute, subacute, perioperative, chronic), including special populations
- Differences in opioid prescribing for acute pain
  - CDC: ≤3 days is usually sufficient, ≥7 days is rarely needed; no postop recommendation
  - AMDG: usually <14 days; for postop pain, do not discharge >2 weeks supply of opioids and many may require less. Continued opioid prescribing requires re-evaluation
- Differences in dose threshold
  - CDC: use caution when increasing ≥50 mg/d MED and avoid increasing ≥90 mg/d MED without justification
  - AMDG: do not escalate >120 mg/d MED without pain specialist consultation

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DR. ROBERT BREE COLLABORATIVE

Bree/AMDG Dental Guideline Recommendations

- Conduct a thorough history including dental and medical
- **Prescribe non-opioid analgesics as first line**
- Consider pre-surgical or pre-emptive medication
- **If an opioid is warranted, follow the CDC guideline (lowest effective dose of immediate-release opioids; ≤ 3 days will be sufficient)**
  - **Limit to 8-12 tablets for adolescents and young adults through 24 years old**
  - Avoid opioids when patient/parent requests no opioid prescription or patient is in recovery and at high risk of relapse for SUD
- Educate on appropriate use, duration and adverse effects of opioids and share information on disposal of leftover opioids
- Support patients with SUD who are undergoing dental procedure

WA Bree Opioid Metrics

General prescribing	
• Prevalence of opioid use	% with ≥1 opioid Rx of all enrollees, by age
Long-term prescribing	
• Chronic opioid use	% with ≥60 days supply of opioids in the quarter
• High dose use	% with doses ≥50 and ≥90 mg/day MED in chronic opioid users
• Concurrent use	% with ≥60 days supply of sedatives among chronic opioid users
Short-term prescribing	
• Days supply of first Rx	% with ≤3, 4-7, 8-13, and ≥14 supply among new opioid patients
• Transition of chronic use	% new opioid patients transitioning to chronic use the next quarter
Morbidity and Mortality	
• Opioid overdose deaths	Rate of overdose deaths involving opioids
• Non-fatal overdoses	Rate of non-fatal overdoses
• Opioid use disorder	Rate of opioid use disorder among patients with ≥3 quarters of use

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ESHB 1427 – Prescribing Opioids

Chapter 297, Laws of 2017

- Adopt rules establishing requirements for prescribing opioids by January 1, 2019
  - May contain exemptions based on education, training, amount of opioids prescribed, patient panel and practice environment
- Must consider AMDG and CDC guidelines
- May consult with Department of Health, University of Washington and professional associations of osteopathic physicians and surgeons in the state

http://app.leg.wa.gov/billsummary?BillNumber=1427&Year=2017

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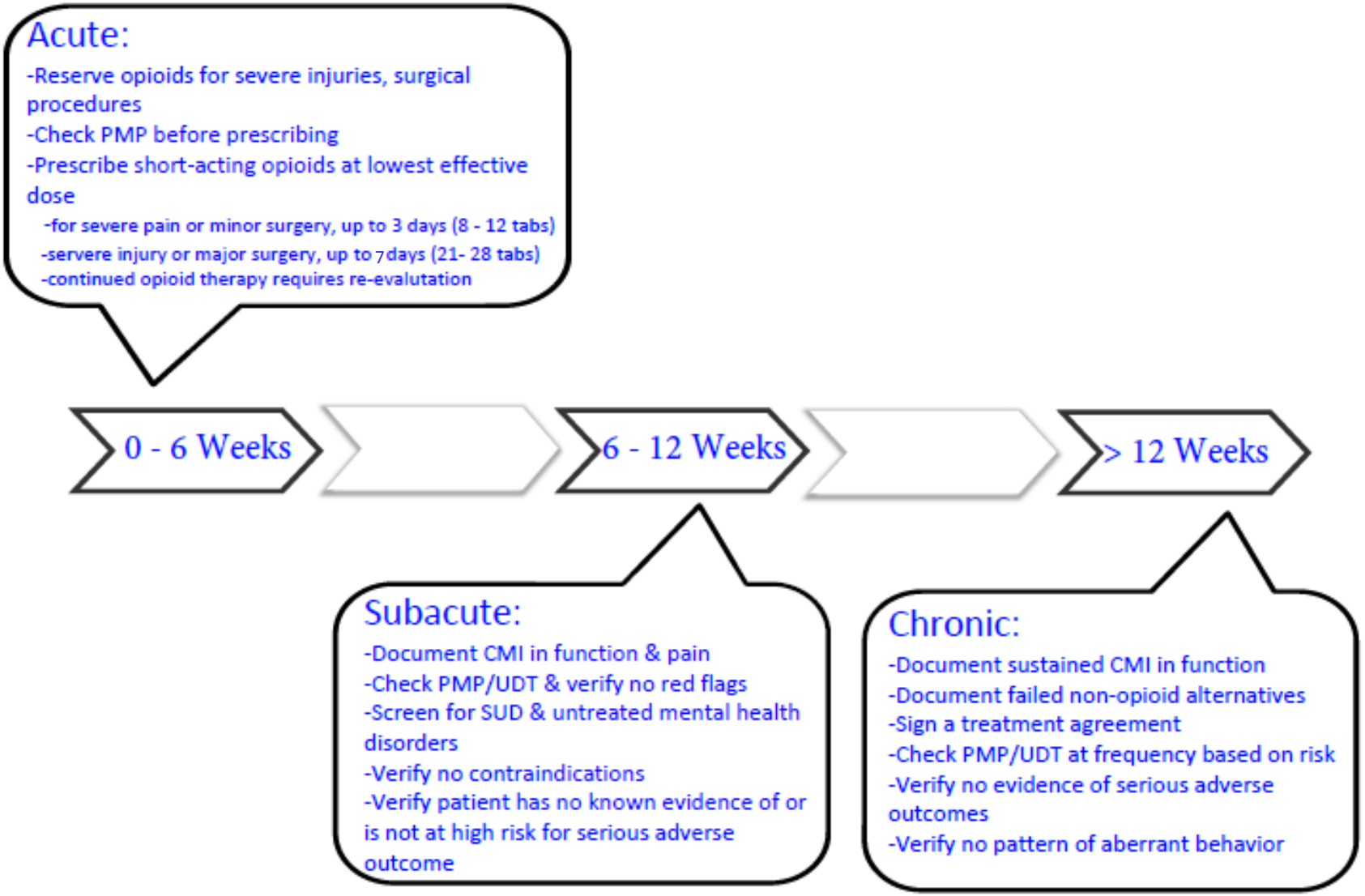
Approach to New Rules

- Do not apply to palliative, hospice or other end-of-life care
- Focus on preventing the next cohort from dependence, addiction and overdose
  - Consider continuing education to increase awareness of effective pain management for all opioid prescribing, risk for abuse and opioid use disorder and proper storage and disposal not just for long-acting opioids
  - Update existing pain management rules for chronic non-cancer pain
  - Add new rules on potential topics such as opioids for acute and perioperative pain, during the subacute phase and for special populations (children, pregnancy, older adults)

Opioid Prescribing Timeline



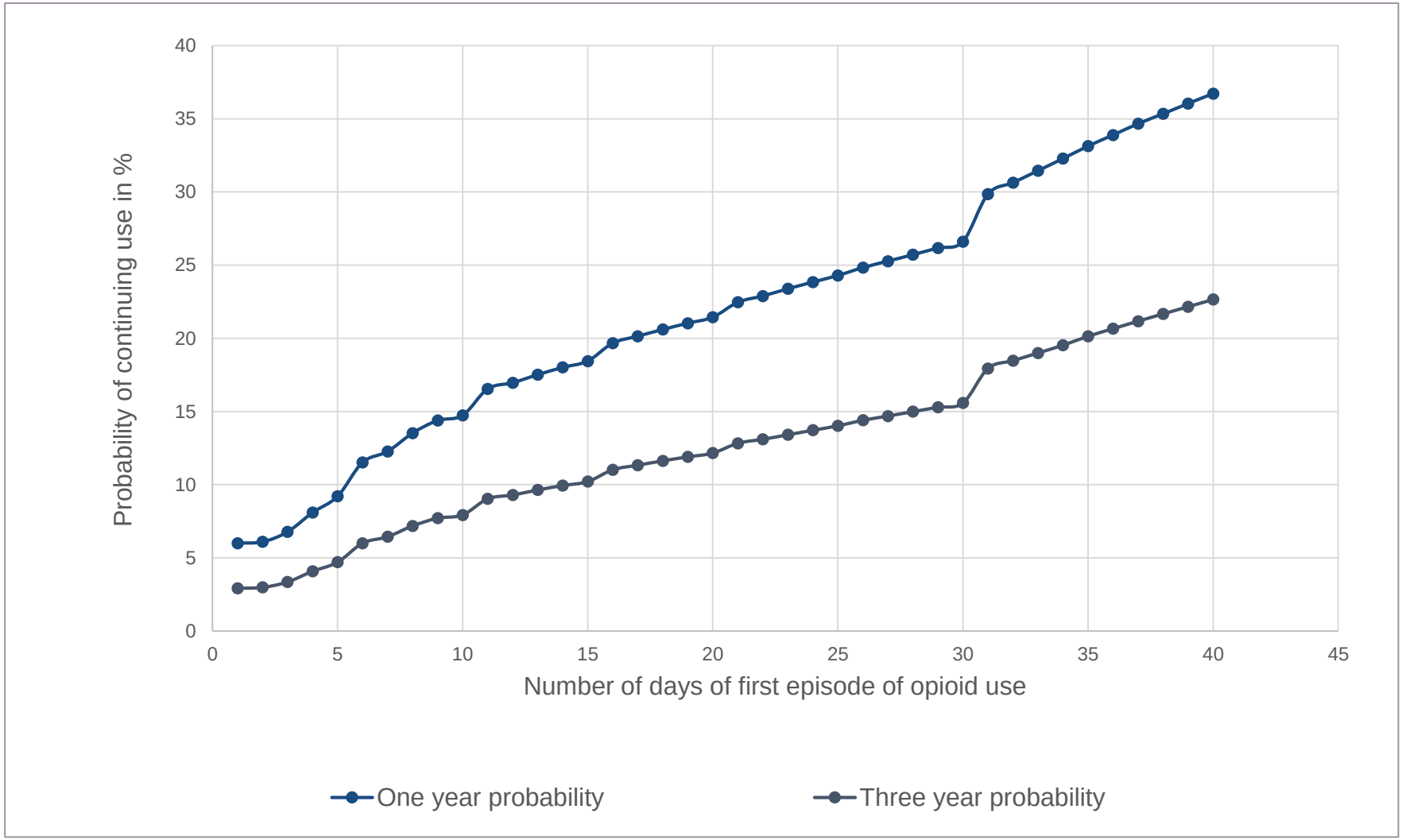
Acute Opioid Prescribing in Adults by Specialty

Table 6: **Number of pills by specialty:** Means, medians, and selected quantiles of the number of tablets dispensed per prescription to adults age 20 and older with acute opioid prescriptions between July 1 and December 31, 2015 ($N = 445{,}799$).

Provider specialty	N	mean	median	75th %tile	90th %tile	99th %tile
State Total	445,799	29.7	20.0	30.0	60.0	144.0
Dentist	84,136	17.6	16.0	20.0	25.0	35.0
Dermatology	2,472	17.8	15.0	20.0	25.0	42.0
Emergency Medicine	35,946	16.7	15.0	20.0	21.0	45.0
Family Medicine	52,543	38.9	30.0	40.0	84.0	210.0
Internal Medicine	23,304	52.3	30.0	60.0	100.0	360.0
Obstetrics & Gynecology	19,531	29.6	30.0	40.0	50.0	80.0
Ophthalmology	2,098	18.7	20.0	25.0	30.0	56.0
Oral & Maxillofacial Surgery	2,048	25.5	28.0	30.0	30.0	60.0
Orthopaedic Surgery	15,622	49.5	40.0	60.0	80.0	150.0
Otolaryngology	4,591	34.1	30.0	40.0	50.0	100.0
Plastic Surgery	2,650	34.1	30.0	40.0	50.0	70.0
Podiatrist	4,660	35.7	30.0	40.0	60.0	90.0
Specialist	6,885	39.6	30.0	45.0	64.0	180.0
Student	4,617	29.9	20.0	30.0	60.0	120.0
Surgery	15,869	34.7	30.0	40.0	50.0	80.0
Urology	5,106	25.9	30.0	30.0	40.0	60.0
other	10,369	41.9	30.0	60.0	90.0	224.3
unknown	153,352	29.1	20.0	30.0	60.0	128.5

Source: DOH Prescription Monitoring Program Data

Continued Use by Initial Days of Therapy



Shah et al. MMWR 2017 Mar 17;66(10):265-9

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Prescribing in the Acute Non-Postoperative Phase

(0 – 6 weeks from injury)

- Goal – Decrease number of pills dispensed for acute pain
  - Reserve opioids for severe injuries or medical conditions or when non-opioid alternatives are ineffective or contraindicated (AMDG)
  - Check the state's Prescription Monitoring Program (PMP) to ensure history is consistent with record before prescribing (AMDG)
  - Prescribe immediate-release opioids at the lowest effective dose (CDC/AMDG/Bree)
    - In general, up to 3 days (e.g. 8 – 12 tablets)
    - For severe injuries, up to 7 days (e.g. 21 – 28 tablets)
    - Exception with documented justification, may extend to 14 days
  - Write on the prescription that the patient may get partial fill (CARA/Pharmacy Quality Assurance Commission)

Education Decreases Opioid Prescribing After Surgeries

- Education to surgical residents, associate providers and attendings at Dartmouth-Hitchcock Medical Center
  - Use of non-opioid analgesics, reserve opioids for persistent pain
  - **Prescribe the following number of opioid pills for partial mastectomy (PM) #5, sentinel lymph node biopsy (SLNB) #10, laparoscopic cholecystectomy (LC) #15, laparoscopic inguinal hernia repair (LIH) #15, open inguinal hernia repair (IH) #15**
- Between June 2016 and September 2016, there were 246 surgeries

TABLE 2. Comparison of Opioid Prescriptions Pre versus Post Provider Education

	Number of Cases		Mean Number of Opioid Pills Prescribed (SD)			Median Number of Opioid Pills Prescribed		Range	
Operation	Pre	Post	Pre	Post	*P*	Pre	Post	Pre	Post
PM	175	58	19.8 (10.2)	5.1 (4.1)	0.0001	20	5	0–50	0–20
PM SLNB	112	62	23.7 (11.3)	9.6 (2.4)	0.0001	20	10	0–60	5–15
LC	240	58	35.2 (16.9)	19.4 (7.2)	0.0001	30	15	0–100	0–40
LIH	80	27	33.8 (9.0)	19.3 (7.3)	0.0001	30	15	15–70	0–30
IH	85	18	33.2 (15.7)	18.3 (8.7)	0.0003	30	15	15–120	0–40

TABLE 4. Opioid Pills Taken

Operation	PM	PM SLNB	LC	LIH	IH	Total
Patients	58	62	58	27	18	224
No. surveyed (%)	34 (58.6)	42 (67.7)	42 (72.4)	20 (74.0)	10 (38.9)	148 (66.0)
Pills prescribed (n)	162	398	823	390	140	1913
Pills taken (%)	59 (36.4)	75 (18.8)	307 (37.3)	187 (47.9)	28 (20.0)	656 (34.3)
Mean no. of pills taken (SD)	1.8 (3)	1.9 (3)	7.5 (8.3)	9.7 (10.7)	2.8 (7.7)	
Refills	0	0	0	1	0	1

Hill et al. Ann Surg 2017 Mar 6. doi: 10.1097/SLA.0000000000002198

From: **New Persistent Opioid Use After Minor and Major Surgical Procedures in US Adults**

JAMA Surg. 2017;152(6):e170504. doi:10.1001/jamasurg.2017.0504

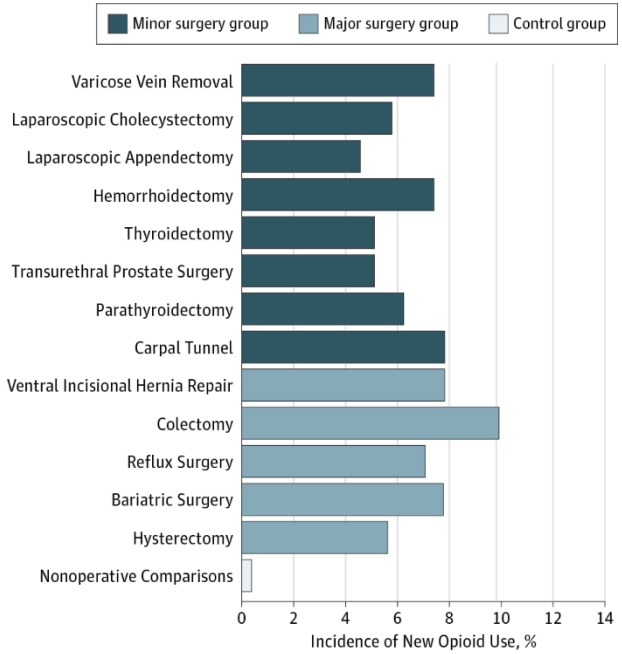

Figure Legend:

Incidence of New Persistent Opioid Use by Surgical Condition The incidence of new persistent opioid use was similar between the 2 groups (minor surgery, 5.9% vs major surgery, 6.5%; odds ratio, 1.12; SE, 0.06; 95% CI, 1.01-1.24). By comparison, the incidence in the nonoperative control group was only 0.4%.

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Prescribing for Acute Post-operative Phase

(0 – 6 weeks from surgery)

- Goal – Decrease number of pills dispensed for acute pain
  - Check the PMP to assess risk for potential postoperative over-sedation, respiratory depression and/or difficult to control pain (AMDG)
  - Establish timeline for tapering postop opioids and identify provider who will manage postop pain; inform patient and family of plan (AMDG)
  - Prescribe immediate-release opioids at the lowest effective dose (AMDG)
    - Minor surgeries, up to 3 days (e.g. 8 - 12 tablets)
    - Major surgeries, 3 to 7 days (e.g. 12 - 28 tablets)
    - Exception with documented justification, may extend to 14 days.
    - Continued opioid therapy requires re-evaluation
  - Write on the prescription that the patient may get partial fill (CARA/Pharmacy Quality Assurance Commission)

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Clinically Meaningful Improvement

- Use of opioids for subacute and chronic pain should result in clinically meaningful improvement (CMI) in function and pain and therefore, quality of life
  - CMI is an improvement in pain AND function of at least 30% as compared to the start of treatment, or in response to a dose change
- A decrease in pain intensity in the absence of improved function is not considered meaningful improvement except in very limited circumstances such as catastrophic injuries (e.g. multiple trauma, spinal cord injury, etc.)
- Opioid treatment that focuses only on pain intensity can lead to rapidly escalating dosage with deterioration in function and quality of life
  - Providers should assess and document function and pain using validated tools at each visit where opioids are prescribed

Quick Validated Tools to Measure CMI

Figure A. Three Item PEG Assessment Scale

1. What number best describes your pain on average in the past week:

0 1 2 3 4 5 6 7 8 9 10

No pain — Pain as bad as you can imagine

2. What number best describes how, during the past week, pain has interfered with your enjoyment of life?

0 1 2 3 4 5 6 7 8 9 10

Does not interfere — Completely interferes

3. What number best describes how, during the past week, pain has interfered with your general activity?

0 1 2 3 4 5 6 7 8 9 10

Does not interfere — Completely interferes

Krebs et al. J Gen Intern Med 2009;24:733-8

Figure B. Two Item Graded Chronic Pain Scale

Graded chronic pain scale: a two-item tool to assess pain intensity and pain interference

In the last month, on average, how would you rate your pain? Use a scale from 0 to 10, where 0 is "no pain" and 10 is "pain as bad as could be"? [*That is, your usual pain at times you were in pain.*]

No pain — **Pain as bad as could be**

0 1 2 3 4 5 6 7 8 9 10

In the last month, how much has pain interfered with your daily activities? Use a scale from 0 to 10, where 0 is "no interference" and 10 is "unable to carry on any activities."

No interference — **Unable to carry on any activities**

0 1 2 3 4 5 6 7 8 9 10

Turk et al. Handbook of Pain Assessment. 3rd Edition: Guilford Publications;2011

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Prescribing in the Subacute Phase

(6 – 12 weeks from injury or surgery)

- Goal – Decrease number of patients transitioning from acute to chronic opioid use
  - Prescribe opioids during the subacute phase only if (AMDG/CDC)
    - ✓ Patient experienced CMI in function and pain
    - ✓ PMP record is consistent with prescribing record and patient's report
    - ✓ Baseline urine drug test did not show red flags (e.g. presence of cocaine, heroin, alcohol, amphetamine/methamphetamine or non-prescribed drugs)
    - ✓ Patient was screened for substance use disorder, risk of opioid addiction and untreated mental health disorder
    - ✓ There are no FDA or clinical contraindications (e.g. current substance use disorder, history of opioid use disorder or prior overdose)
    - ✓ Patient has no known evidence of or is not at high risk for serious adverse outcome from opioid use (e.g. COPD, asthma, sleep apnea)
  - Prescribe immediate-release opioids at the lowest effective dose (AMDG)
  - Avoid transitioning to chronic opioid use for centralized pain conditions for which evidence of efficacy is low and risk of harm is high (e.g. nonspecific low back pain, fibromyalgia, headaches)

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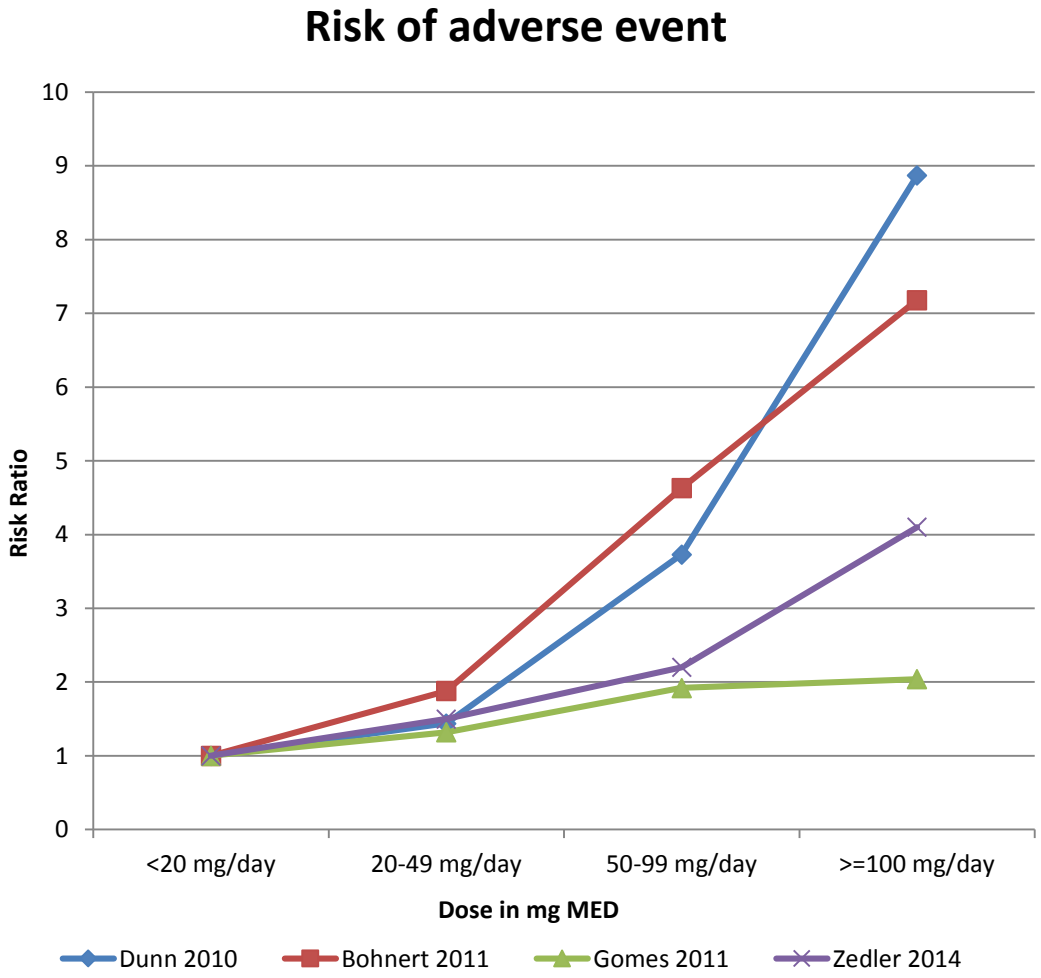
More Evidence on Opioid Dose-related Risk



- 2007– AMDG dose threshold at 120 mg/day MED
- 2009 – CDC recommends 120 mg/day MED
- 2011 – WA Boards and Commissions threshold at 120 mg/day MED
- **2012 – CT workers' compensation threshold at 90 mg/day MED**
- **2013 – OH Medical Board threshold at 80 mg/day MED**
- **2013 – ACOEM threshold at 50 mg/day MED**
- **2014 – CA workers' compensation threshold at 80-120 mg/day MED**
- **2016 – CDC recommends 50 & 90 mg/day MED**

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Prescribing in the Chronic Phase –
(>12 weeks from injury or surgery)

- Goal – Reduce risk of overdose among those on chronic opioid therapy
  - Consultation – eliminate mandatory consultation and exemption (e.g. Seattle Pain Centers)
  - Dose threshold – decrease to 50 mg/day MED for opioid-naïve patients with risk factors and 90 mg/day for opioid-naïve patients without risk factors (CDC)
    - Exception for medication-assisted treatment
    - Patients who are already above 90 mg/day MED should not have their doses increased further. They should be reassessed to optimize therapy with a goal of lower doses
  - PMP – require checking the PMP under Patient Evaluation, Episodic Care and Periodic Review (AMDG)
  - Tapering or Weaning – add the following scenarios under Periodic Review (AMDG)
    - Patient requests opioid taper
    - Patient has experienced an overdose event

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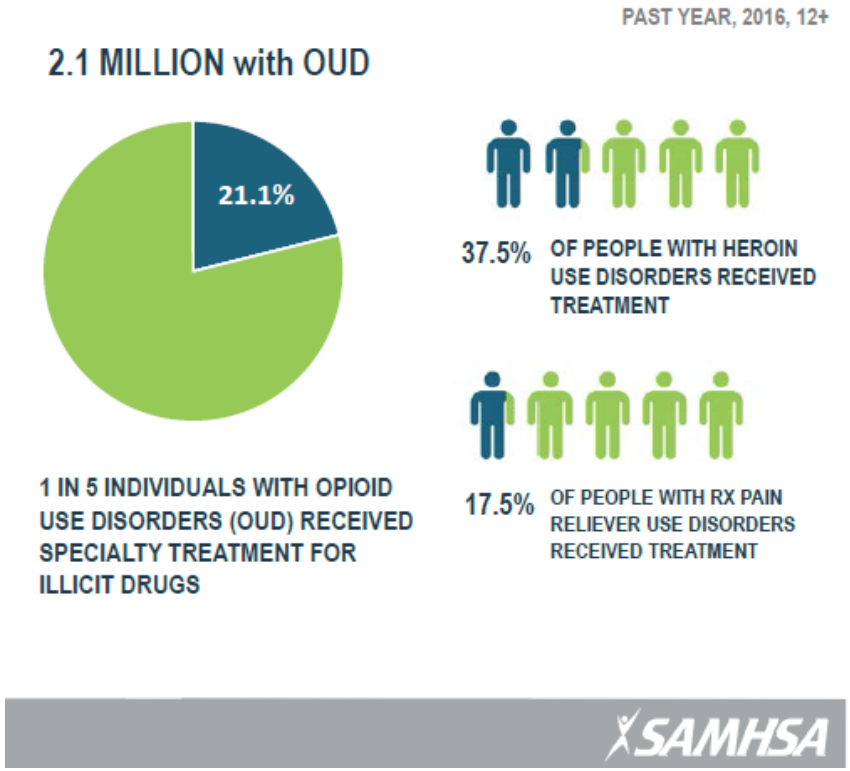
Recognizing Opioid Use Disorder

- Goal – Reduce risk of overdose among those on chronic opioid therapy
  - Assess for opioid use disorder or refer for a consultation with an addiction specialist (CDC/AMDG)
  - Be knowledgeable about medication-assisted treatment options
    - Consider obtaining a DATA 2000 waiver to prescribe buprenorphine (AMDG)
  - Prescribe naloxone as a preventive rescue medication for patients with opioid use disorder (AMDG)



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Special Populations …

Acute Opioid Prescribing in Youth by Specialty

Table 6: **Number of pills by specialty, youth age 14–19:** Means, medians, and selected quantiles of the number of tablets dispensed per prescription to children age 14–19 with acute opioid prescriptions between July 1 and December 31, 2015 ($N = 33{,}835$).

Provider specialty	N	mean	median	75th %tile	90th %tile	99th %tile
State Total	33,835	23.7	20.0	30.0	36.0	80.0
Dentist	13,345	22.3	20.0	30.0	30.0	40.0
Emergency Medicine	2,560	15.2	15.0	20.0	20.0	30.4
Family Medicine	1,295	20.6	20.0	25.0	30.0	60.9
Obstetrics & Gynecology	593	27.7	30.0	30.0	40.0	80.8
Oral & Maxillofacial Surgery	946	24.4	20.0	30.0	30.0	50.0
Orthopaedic Surgery	931	48.9	40.0	60.0	80.0	130.0
Otolaryngology	538	39.5	30.0	50.0	70.0	90.0
Pediatrics	475	18.9	16.0	24.0	30.0	60.0
Podiatrist	354	30.4	30.0	40.0	60.0	81.9
Student	385	22.7	20.0	20.0	40.0	90.0
Surgery	683	33.0	30.0	40.0	50.0	80.0
other	839	28.0	22.0	30.0	50.0	100.0
unknown	10,891	23.6	20.0	30.0	40.0	90.0

Source: DOH Prescription Monitoring Program Data

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Opioids in Adolescence and Future Misuse

- Prospective panel data from Monitoring the Future Study
  - N=6220 surveyed in 12th grade and followed up through age 23
- Legitimate opioid use before high school graduation is independently associated with a 33% increase in risk of future opioid misuse after high school
- Association is concentrated among high schoolers who have little to no history of drug use and strong disapproval of marijuana use at baseline

Miech et al. Pediatrics 2015:peds. 2015-1364

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Prescribing Opioids in Children and Adolescents

- Goal - Minimize opioid exposure in children and adolescents
  - Prescribe non-opioid analgesics as FIRST line for most acute pain. In rare cases where opioids are warranted (e.g. 3rd, sports injuries), limit to 8-12 tablets (Bree/AMDG)
  - Avoid opioids in the vast majority of chronic non-cancer pain problems (e.g. abdominal pain, headache, pervasive musculoskeletal pain) in children and adolescents (AMDG)
  - Consult a pediatric pain specialist for chronic pain problems (e.g. osteogenesis imperfecta, epidermolysis bullosa) where opioids may be indicated (AMDG)

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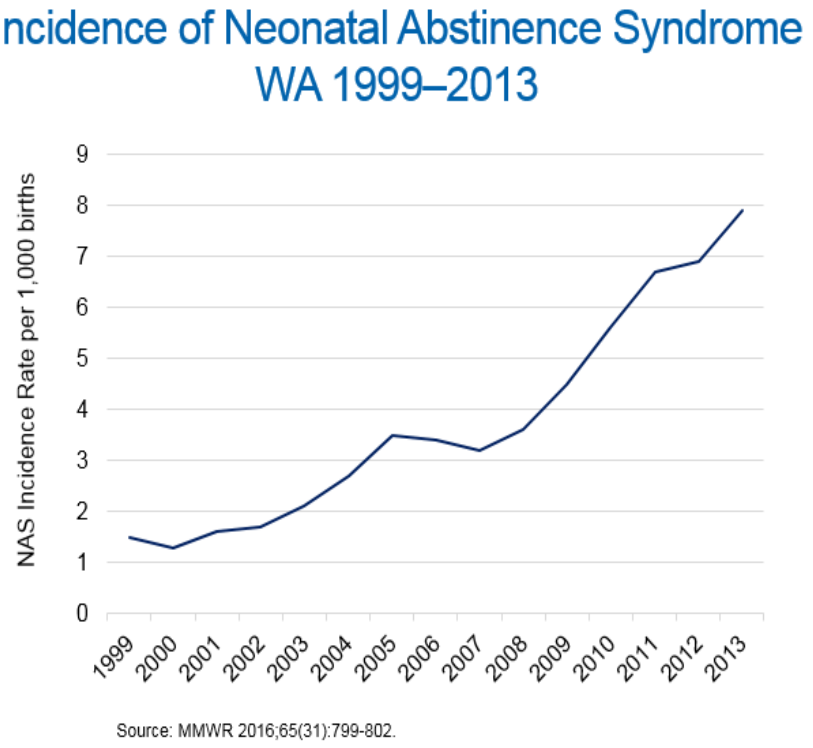
Prescribing Opioids During Pregnancy

- Goal – Reduce risk of neonatal abstinence syndrome
  - Counsel women of child-bearing age who use opioids about the potential maternal, fetal and neonatal risks (AMDG)
    - 1/3 of reproductive-aged women filled a prescription for an opioid
    - ~50% of all pregnancies are unintended
  - Avoid initiating chronic opioid therapy (COT) during pregnancy
  - Require informed consent which emphasizes fetal and neonatal risk and offers choice to taper for COT patients who become pregnant
  - Assess pregnant women taking opioids for opioid use disorder and if present, refer to specialist (AMDG)



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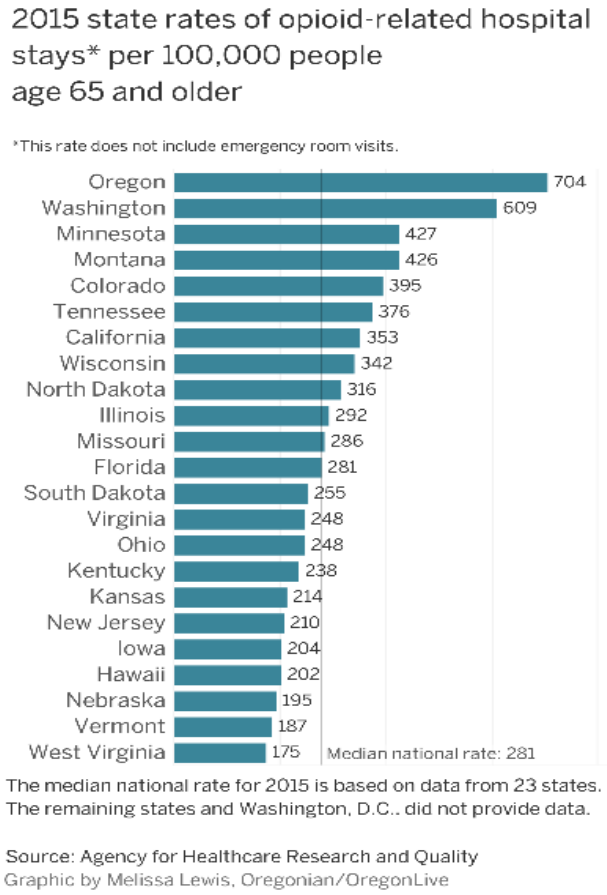
Prescribing Opioids in Older Adults

- Goal – Reduce risk of falls and fractures
  - Follow same best practices for prescribing opioids (AMDG)
  - Prescribe immediate-release opioids at the lowest effective dose (AMDG)
    - Initiate opioid therapy at a 25% to 50% lower dose than that recommended for younger adults



Rapidly increasing mortality in middle aged, lower educated whites

Case and Deaton, PNAS, 2015

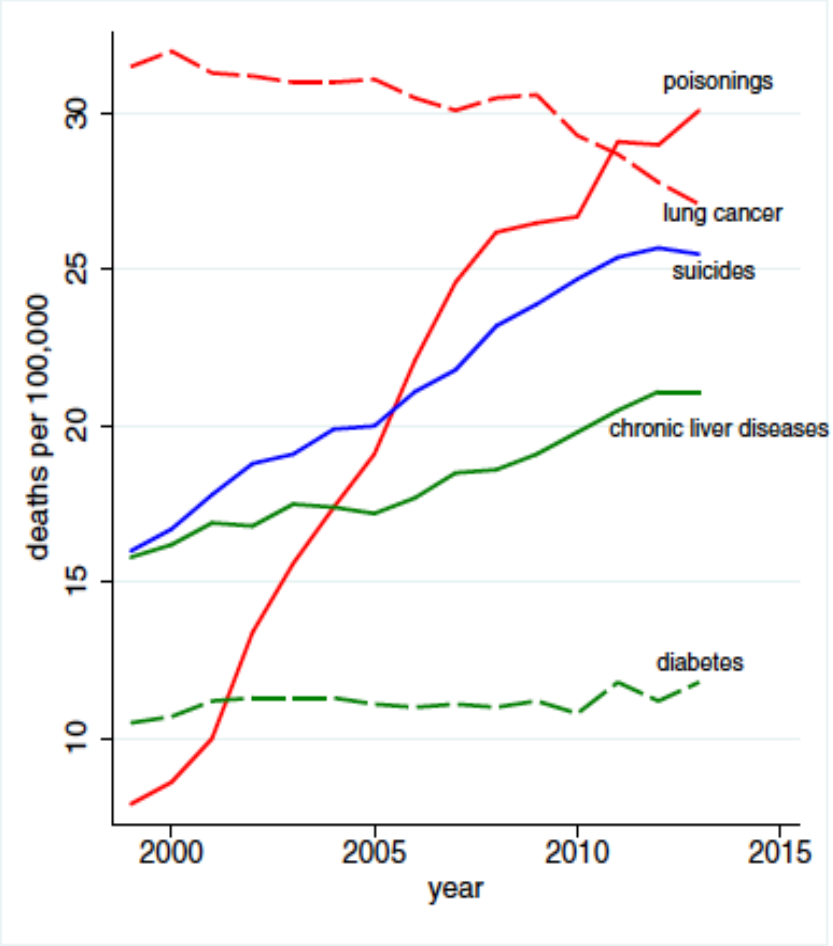


Fig. 2. Mortality by cause, white non-Hispanics ages 45–54.

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THANK YOU!

For questions or feedback, please e-mail Gary Franklin
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